DFB (Care) Limited

Palm Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 6 and 15 June 2017 was unannounced. Palm Court Nursing Home provides accommodation and personal and nursing care for up to 53 people with care and support needs related to age, who may also have a diagnosis of dementia. There were 21 people living in the home at the time of our inspection.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home has been inspected four times since 2015. At the inspections in December 2015 and January 2016, June 2016 and September 2016 we found multiple breaches of regulation. At the inspection in September 2016 the home was rated as inadequate and placed into special measures. Following this inspection the CQC took enforcement action in accordance with its procedures.

At this inspection we found the rating for the service remains 'Inadequate' and the service will continue to be in 'special measures'. Although there had been some minor improvements, we found the provider and registered manager had not made the significant improvements expected and remain in breach of a range of regulations of the HSCA 2008 (Regulated Activities) Regulations 2014. The local authority was not currently admitting people to the home, due to the ongoing and significant concerns identified by CQC.

The provider and registered manager continued to fail to act on feedback provided by the local authority, an external consultant and CQC. They had not provided effective leadership and direction at the service. The required improvements had not been made with regard to activities and personalised care and these were continuing breaches of these regulations. People were not always treated a kind and caring way, and did not have their safety protected at all times. The provider and registered manager's auditing systems had not identified areas of practice that needed to improve and their quality assurance and monitoring system continued to be ineffective

Staff did not consistently treat people with dignity and respect, although we did observe some good practice in this area. People did not always have their preferences and choices met, and people's needs were not always accurately assessed or recorded in their care plans. People's care needs had not always been properly identified and the most up to date and relevant information about each person was not available to staff, to help them meet people's care needs. Care plans were complicated and did not consistently contain accurate or up to date information about the person. There was a risk staff would provide the wrong care for people because of this.

Although the provider had increased the amount of training available for staff, they did not make sure this training was effective. We observed staff using unsafe moving and handling techniques, as well as providing support to people that was not centred on their individual needs. Staff learning and competency were not assessed after training, so the provider and registered manager could not be assured that staff training had been effective.

Risk assessment and risk management practices continued to put some people's health at risk. Senior staff and the registered manager were not clear about why they were assessing risk, or the purpose of a robust risk management plan to keep people safe.

Food was of good quality and people gave us positive feedback. However, people's individual dietary needs were not taken into account when food was prepared, and people were not supported to have a positive mealtime experience.

Although there were more staff on duty since the last inspection, they were not always deployed appropriately. There were enough staff to meet people's basic care needs, but not enough staff to support people to spend their time as they wished, such as go out for a walk. Recruitment practices had improved and all of the relevant checks were completed before staff began work.

A complaints procedure was in place. Staff addressed issues they could deal with at the time and referred other concerns to the registered manager or provider. However, some relatives felt the management did not listen to their concerns or respond to them properly. Staff felt supported by the registered manager, and gave positive feedback about them.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards, and the relevant DoLs applications had been made. Staff had attended safeguarding training and they knew how to protect them from the risk abuse. People said they were comfortable and relatives told us they thought people were safe.

The overall rating for this service continues to be inadequate and the service remains in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found four continuing and one new breach of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

CQC is currently considering what action we will take against the provider.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

There were not always enough staff to ensure people received the support they needed in a flexible way. Risk assessment and risk management practices did not always protect people's safety.

Staff knew what they needed to do to keep people safe from abuse and were clear about what they should do to safeguard people.
Recruitment practices had improved and the relevant checks were completed before staff began work.

Appropriate systems were in place to ensure people were given their prescribed medicines. Accidents and incidents were recorded and investigated.

Is the service effective?

Requires Improvement

The service was not always effective.

Although the provider had improved the amount of training provided for staff, the training was not always effective. We observed poor practice from staff who had completed training, including unsafe moving and handling.

People did not always have their individual nutritional needs met, although feedback about the food was positive. People were not well supported with their meal time experience but did have their hydration needs met.

Staff understood the Mental Capacity Act (2005) and Deprivation of Liberty safeguards (DoLs). All of the appropriate DoLs referrals had been made.

People were supported to maintain good health and had access to health care services when they needed it.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not consistently treat people with dignity and respect. People did not have their independence promoted and staff did not always show concern for people's well-being.

Although staff said people's choices and preferences were understood we did not always see people being asked to express their choices. The provider had not ensured that staff behaviours between themselves and their colleagues were appropriate.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have their individual needs properly assessed and their care plans did not contain the most up to date or accurate information.

People were not supported with meaningful activities, or to maintain involvement in the community.

The provider did not always respond to people's complaints appropriately.

Is the service well-led?

Inadequate

The service was not well led.

Although there had been some improvements, the provider and registered manager had not made enough improvements to meet the requirements of the regulations.

Quality monitoring systems had been developed. However, they had not identified areas of poor practice observed throughout this inspection.

Staff and relatives gave positive feedback about the new registered manager and acknowledged they had been trying hard to make improvements.

Care Quality Commission

Palm Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 and 15 June 2017 and was unannounced. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we looked at and reviewed all the current information we held about the service. This included notifications that we received. Notifications are events that the provider is required by law to inform us of. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make

We spoke with six people who use the service, four relatives, three registered nurses, six care staff, the chef, a kitchen assistant, the registered manager and the nominated individual who is also the owner of the home and a director of the provider's limited company. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed staff providing care and support to people. We spoke with a dietician and speech and language therapist (SALT) who both visited the service on the second day of the inspection. During and after the inspection we spoke with two quality monitoring officers from the local authority by telephone.

We reviewed four people's care plans and associated risk assessments, the recruitment and training records for three members of staff, quality monitoring audits and other records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

At our inspection on 30 December 2014 and 12 January 2015 we found the provider was not meeting the legal requirements in relation to the safety and security of the home and staffing levels. We carried out a focused inspection on 15 June 2015 as we had received information that there were not enough staff to keep people safe and we found improvements were needed in relation to staffing levels. The provider sent us an action plan stating improvements would be completed by 12 August 2015. We inspected the service in September 2016 and found the provider had met the regulation regarding security and safety of the premises. However, we found the provider had not met the legal requirement in relation to staffing, which was a repeated breach from the inspection of December 2014 and January 2015.

This inspection was a full comprehensive to check if the provider had met the breaches of regulations regarding staffing numbers and safe moving and handling. We found the provider was not meeting the legal requirements to provide adequate staffing and safe moving and handling and we identified other areas where improvements were needed. This was a continuous breach from the inspection of September 2016.

People said they felt comfortable living at Palm Court Nursing Home. One person told us they were safe and staff, "Come in my room to check on me at night, so they must be keeping an eye on me" and, "I am a bit wobbly on my Zimmer but they help me." Another person agreed they felt safe living in the home and said, "The girls are lovely looking after me." However, although people told us they felt safe, we found examples of care that were not safe and put people and staff at risk.

At the last inspection in September 2016, we found there were not enough staff on duty to keep people safe. At this inspection feedback and observations about the number of staff on duty was mixed. One person said, "There always seems to be plenty of staff, today there is more than normal because you're here but there is enough I'd say." A relative commented, "There is sometimes a clear lack of staff on duty." The provider used a tool to assess people's care needs and match staffing levels accordingly, and we found there were enough staff on duty to meet people's basic needs. However, there were not always enough staff to support people to engage in a meaningful activity, which included going outside. For example, we observed that many people sat in the lounge for long periods without any interaction with staff. One person tried to attract the attention of staff and although a member of staff saw this they did not sit and talk to the person or offer an activity. Another person wanted to go out for a walk, but staff did not offer to go with them and they were unable to go out on their own.

One member of staff told us there was enough staff "99.9%" of the time. They said if someone went off sick they could, "Generally get cover" and, that they had time to sit and chat with people in the afternoons. "They (people) need your time, and you have to make time." Another member of staff told us it would be nice to take people out more often, such as to the local park for ice cream like they, "Used to", but people's needs had increased and they, "Need more staff" to be able to take people out. The provider had failed to ensure that people's preferences were met, as there were not enough staff on duty. This is a continuous breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said they had attended training in moving and handling and discussed the use of aids such as hoists, handling belts and the correct way to assist people using walking aids. However, on three occasions we observed staff did not follow current guidance to support people to move around the home safely. A member of staff assisted a person to stand up and walk to the bathroom. However, they failed to give the person clear support and guidance, or prompt the person in accordance with best practice, to help them stand up as independently as possible. This caused the person to become frustrated with staff, which in turn led the staff to rush and actually delayed the person getting to the bathroom.

On two separate occasions staff used unsafe moving and handling techniques. They placed their hands underneath the person's arms when the person was in a reclined position, and then assisted them to stand. This is known as a 'drag' lift. The 'drag' lift is any method of handling where the care worker places a hand or arm under the person's armpit. Use of this lift can result to damage of the spine, shoulders, wrist and knees. For the person lifted, there is the potential of injury to the shoulder and soft tissues around the armpit. Risk of fractures to the bone of the upper arm and dislocation of the shoulder is also a possibility. The Royal College of Nursing provided the following guidance about the use of this lift technique 'Unless there is an emergency (needing immediate action to avoid serious harm to a patient's health) drag lifts must not be carried out.' This placed the people and members of staff at risk and could have caused harm or injury to both.

We spoke with the registered nurse who was responsible for training staff in safe moving and handling techniques. We discussed when they last had manual handling training themselves. They could not remember and did not provide us with evidence to demonstrate when they had completed this training. Although the registered nurse confirmed they had received 'train the trainer' training, to help them teach others, they had not received advanced training to make sure they themselves were up to date and aware of best practice for moving and handling techniques. The nurse confirmed they provided training for staff in April 2017, although they did not have up to date moving and handling training themselves. They also confirmed they had not followed up the training provided with observational assessments of staff competency.

The provider had continued to fail to ensure that staff had the skills and expertise to make sure people experienced safe care and treatment. This is a continuous breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the registered manager had received additional training and feedback from ESCC specifically about managing risk and keeping people safe, risk assessment and risk management practices remained unsafe at times. For example, one person had been assessed as at risk of choking. There was a risk management plan in place devised by the speech and language therapist (SALT) which gave staff information on what to do to prevent the person choking such as, 'feed (name) in an upright position,' and, 'small sips of liquid,' and, 'unfortunately due to (names) dementia they may continue to drink too quickly and these behaviours will require management by their carers'. We observed this person drinking on their own, they began to cough loudly and the coughing worsened, but it took several minutes for staff to respond. When staff did, they took the right action and the person stopped coughing. On this occasion, staff had not followed the person's risk management plan that the person should be supported to have small sips of liquid and did not react to the person's coughing quickly enough. This could have caused significant harm to the person, and the registered nurse confirmed they had only recently been taken to hospital after a similar choking incident.

We asked staff how they made sure people's nutritional needs were met and how any risk to people's nutritional intake was monitored. The nurse and registered manager told us they used the Malnutrition

Universal Screening Tool (MUST). MUST is a five-step risk and screening tool used to identify adults who are malnourished or at risk of malnutrition, either under nutrition or being overweight. The tool also includes management guidelines which can be used to develop a care plan to make sure a person's nutritional needs are met. Every person had a MUST score in their care plan and the Body Mass Index (BMI) had been used to identify if peoples' weight was within a healthy range.

We found the MUST tool had not always been used effectively to support people's specific needs. For example, the registered manager and nurse said one person was overweight. They had spoken with them and made some changes, such as adding fruit to their diet, to assist their weight management. However, the chef told us all of the food prepared in the kitchen, at the instruction of the provider, was fortified with high fat foods, such as cream, cheese or butter. Staff had not considered how small changes to the meals could assist the person to lose weight and reduce the risk to their health, such as making porridge, the person's preference for breakfast, with water rather than milk to reduce the number of calories.

We spoke with a dietician who visited the home on the second day of the inspection and they confirmed the MUST had not been used correctly. They also confirmed that while fortifying food may be appropriate for some people, it depended on the individual, and food should be prepared and served to suit each person's specific dietary need. This in turn makes sure any risk to people's health from poor nutrition was reduced as much as possible. The dietician said that although people were well nourished they were sometimes concerned about staff thought processes into how, why and what they are doing with regards to nutritional intake. They commented, "I wouldn't want them to blanket fortify everyone's meal as they may go into the overweight category." The provider had not followed MUST guidance and this could put people at an increased risk of ill health.

The provider had failed to ensure that risk was managed safely and that staff followed good practice guidelines to make sure that risk was a low as reasonably possible. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also observed some staff using safe moving and handling techniques. Staff supported people to transfer from wheelchairs to armchairs in the lounge using a hoist. Staff explained what they were doing and asked people where they wanted to sit. They said, "We are going up", "Moving you back now" and, "We are going down," to make sure people felt safe and comfortable while they were being moved and, staff checked they were comfortable before assisting other people. Senior staff said they would intervene if they observed staff assisted people incorrectly or did not offer appropriate care. One member of staff said, "They might get fed up with me, but I don't care."

The provider had made improvements in their staff recruitment procedures. Staff recruitment records showed all of the relevant checks had been completed before staff began work. These included disclosure and barring service (DBS) checks, evidence of conduct in previous employment and proof of identity. A DBS check is completed before staff begin work to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. Staff were not allowed to start work until these checks had been completed. This helped to ensure that staff employed by the service were safe to work with the people they cared for.

Accidents and incidents were recorded and investigated and when needed action was taken to help prevent the incident from happening again. For example, one person had been assessed as being unsafe to leave the home on their own. The person had recently left the home unexpectedly and without letting staff know. The registered manager put a plan in place to reduce the risk of this happening again. They had reviewed the person's care plan and introduced an interaction chart for staff to record how the person spent their time.

Staff said they observed the person discretely as they walked around the building. Staff said they did not restrict the person, but made sure they knew where they were and, the door code had been changed, "Which means no one can leave or enter without us knowing, as they have to ring the bell to be let in and ask us to open the door for them to leave."

As far as possible, people were protected from potential abuse. Staff knew about safeguarding people from abuse and what action to take if they were concerned a person was at risk. They knew they should raise concerns with the registered manager and they were confident that any issues they raised would be dealt with appropriately. Staff had access to appropriate safeguarding policies and pointed out the contact details for the local authority, which were displayed on the notice board. The registered manager had followed current safeguarding guidelines and had made referrals to the local authority when necessary.

There were safe procedures for ordering, receiving, storing, administering and disposing of medicines and, policies were in place to support staff to give out medicines safely. Medicines administration records (MAR) showed people received their medicines as prescribed. Some people took medicines on an 'as and when required' basis (PRN) and these had clear guidance for staff to follow to ensure they were given as required. For example, one person was prescribed PRN medicine for seizures and the guidance listed when this may be required and what action staff should take if it was not effective. Homely remedy forms had been agreed and signed by the relevant GP, with guidance for staff to follow to assess people's needs if they were unable to communicate them verbally, such as paracetamol for pain.

Care staff applied topical creams as prescribed and they informed the nurse on duty when they had done this. People's cream application was recorded on the person's MAR chart, creams were placed in people's rooms when they were needed and care staff signed they daily records to show when they had been applied. The registered nurse had identified that this could be improved and had discussed, with the pharmacy, the addition of clear guidance about where and how much cream should be applied and a body chart would be used to make this clearer for staff. The pharmacist said this had all been agreed, the body charts were being introduced and clear information would be added to the packaging for the next monthly cycle of medicines.

The provider had a plan to deal with any emergencies. If necessary people could be moved to a nearby home and staff had attended fire training to ensure they were clear about how they could assist people to leave the home if required. One member of staff told us the training had been very good. They had used role play to understand how they would support people living with dementia to leave the building. "We sat in wheelchairs or used aids, how it feels to be moved and how we can help people. Very good."

Risks to the environment were managed and there was an appropriate maintenance schedule in place to make sure the environment remained safe for people, such as gas and electricity checks and fire equipment. Other safety checks included equipment such as the lift and hoists as well as, legionella and fire extinguishers. There was a maintenance book for staff to record any works that were required and a maintenance person came to the home once a week to complete any repairs. If something was urgent then the maintenance person could be called in at short notice.

Requires Improvement

Is the service effective?

Our findings

At our inspection on the 30 December 2014 and 12 January 2015 we found the provider was not meeting the legal requirements in relation to staff training. At the inspection in September 2016 we found improvements to staff training had not been made which was a continued breach of regulation. At this inspection we found there had been an improvement in the amount of training offered to staff. However, training provided was not always effective with some poor practice being observed on several occasions.

A visitor said they were aware staff received training, but said staff, "Need to know more about what to do with dementia." Staff said they had attended training to support people living with dementia and were positive about the training provided by the In-reach team from East Sussex County Council (ESCC). Staff told us they were required to attend all the relevant training and they were reminded when updates or new training had been arranged.

At previous inspections, people had commented that on occasions they found it hard to talk to and understand staff whose first language was not English. The provider had encouraged staff to attend English for Speakers of Other Languages course (ESOL). The aim of the course was to help staff communicate with people more clearly. However, it was not clear if staff were supported to attend these classes as part of the required training programme and if staff were assisted on a day by day basis to develop language skills whilst working. Staff communicated very well with people in a non-verbal way, although some had difficulty making themselves understood as their spoken English was not clear. A relative said there were four staff in particular who were, "Very good. The rest struggle to communicate due to language barriers." Another family member told us, staff were, "Always there for (name)," but their relative, "Just cannot understand" some staff due to their poor English language skills. Two staff were aware their spoken English was not as good as they wanted it to be, "But we are learning more all the time." Training had not been effective and people continued to find it difficult to talk with staff when English was not their first language.

Staff said the training enabled them to have a good understanding of people's needs, which meant they knew when people needed support or assistance and, if they had any concerns they would talk to the nurse or registered manager. However, we observed that staff did not consistently provide appropriate support when people needed assistance. For example, after lunch one person became upset and complained of stomach pain. A member of staff asked the person what was wrong and they said they needed to use the bathroom. The staff member then walked away and stood in the lounge looking around. When we asked what they were doing to support this person they said could not do anything as they were the only staff in the lounge and they could not leave people on their own. A senior member of staff came into the lounge, but they were not asked to take over supporting people in the lounge until we prompted the member of staff to ask them to do this. The person was then assisted to use the bathroom. There was a clear lack of understanding of the importance of assisting people to use facilities in a timely way so that any discomfort can be prevented or reduced as much as possible.

The provider said at the last inspection they would be inducting any new staff using the Skills for Care framework, supporting staff to obtain their Care Certificate. The Care Certificate is a set of minimum standards that should be covered as part of induction training of new care workers. However, at this inspection we found new staff continued to have a very basic induction which consisted of two days shadowing other staff. When we discussed staff training with senior staff and the registered manager, they were confused about who was responsible for what training. The registered manager said it was them, and the nurse thought they were responsible. Although the registered manager had a basic training plan in place, they acknowledged that, "Training may need to be a bit more structured" and, there was "A lack of embedded knowledge" for staff.

The provider failed to offer effective training to enable staff to understand people's needs so they could offer appropriate support and care for people living with dementia. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed people were served breakfast between 9am and 11.30am. People were offered cereals, sandwiches and fruit or cooked breakfasts, depending on what they wanted to eat. Staff said people preferred to have their breakfast at different times. One person chose to get up early so usually had their breakfast first and another person was eating a cooked breakfast at 11.30am. Lunch was served from midday, and on the first day of the inspection canapes were offered to people at tea time, around 3pm. Supper was served at 5pm. From 7pm to 9pm, or if a person was hungry during the night, snacks and sandwiches were available.
Staff were not able to explain how they had given people choices, and records did not show that people made choices about the timing of their meals. Staff did not feel the amount of food which was left uneaten in the afternoon was because most people had already had enough to eat. In addition, there was a risk that people could eat too much food, as due to their dementia they may not remember when they had last eaten. The timing of the meals had been identified as a concern at our last inspection and the provider and registered manager had not taken action to address these issues.

Staff told us meals were a very important part of people's day, particularly those who did not have regular visitors and they should enjoy this time. However, staff did not promote meals as a positive social experience for people. Staff were task focused and there were limited conversations between people and staff when food was being served or when staff assisted people with their meals. People were not asked where they wanted to sit for lunch, at the dining tables or in their armchair, and most people remained in their armchair. Staff said people preferred to remain in the chairs they had been sitting in since coming into the lounge, but there was no evidence to support that this was each person's choice.

One person sat on their own at the dining table and leant on the table holding their head in their hands before their meal was served and there was very little communication with staff. People sat in groups, but were not given or assisted with their meal at the same time, so some people sat and watched others eating. Another person, who ate independently, fell asleep while less than half way through eating their lunch. A member of staff took the meal away without asking the person if they wanted anymore or to check if the person had actually finished their meal. People were not offered a choice of drink with their meal, or any condiments to enhance their meal time experience. We did observe one person asking for an alternative to the dessert offered, and this was immediately provided.

The provider had failed to ensure that they had assessed the level of support people needed, what people's preferred meal times were or that the food and drink provided was appropriate and met people's individual needs. This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff gave positive feedback about the regular one to one supervision sessions they had with senior staff or the registered manager. Supervision included a self-assessment of how staff thought they were doing, how they felt they fitted in with the staff team, how they supported people and any additional training they wanted to do. The supervisor's assessment included how they felt staff fitted into the team and their observations of the care provided by the member of staff, their training and any other business. However, we saw areas of poor practice such as staff using unsafe practices to assist people to stand, staff not understanding people's dietary needs and not responding promptly to people when they needed assistance. The day to day care staff provided was not effective and not adequately supervised, which could put people at risk of harm. This was an area of practice that requires improvement.

People gave us positive feedback about the quality of the food. One person said the food was good and another that they enjoyed the lunch. A relative told us, "Lunch and breakfast are adequate, and the supper is very good normally, very good." Another relative said, "The lunch always seems good." A visitor said their friend, "Eats really well so the food must be good." The chef had a good understanding of people's preferences and dietary needs, such as diabetic diet and soft or pureed meals. Staff said they weighed people monthly and more often if they had concerns. These were recorded in the care plans and staff told us the GP would be contacted if they had any concerns.

Staff had all been supported to begin additional qualifications in health and social care. The provider had supported a member of staff to become the dignity champion and they had just completed their training. The additional training was specific to the role, and the next step for the dignity champion was to share their knowledge with other staff. The provider had taken steps to improve training in other areas. They had organised drop in sessions once a week, for staff to attend. The times of the sessions were varied to enable as many as staff as possible to attend. Feedback from staff about the training was positive and subjects covered included supporting people with diabetes and dementia care.

Staff and the registered manager had attended training and had an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs).They knew what they should do to protect people who did not have the mental capacity to make some decisions for themselves. The MCA provides a legal framework for acting and making particular decisions on behalf of adults who lack the capacity to make decisions themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and the least restrictive as possible. DoLs referrals had been made where appropriate.

Staff told us that any decisions made on someone else's behalf should always be in their best interests and explained how this could be ensured. For example, the provider planned to improve the older part of the home and had asked people living in those rooms to transfer to the extensions at the rear of the building. One person had not wanted to move, although their friend and social worker both felt this would be a good idea. The registered manager arranged for an independent mental capacity assessor (IMCA) to visit the person and act as their advocate and they agreed that they should remain in their room and not move.

The registered manager knew which people had given another person valid and active lasting powers of attorney (LPA). An LPA is a legal tool that allows people to appoint someone to make financial or health and social care decisions on their behalf. The registered manager understood what an LPA was and made sure they had seen a copy of any LPA and recorded it in people's care plans.

People had access to health care services when they needed them. The visiting dietician and SALT, both confirmed staff had increased the amount of referrals they made, and that referrals were relevant for each person. People's care records noted when they had been referred to health care professional such as the GP and why.

Requires Improvement

Is the service caring?

Our findings

Relatives told us the staff looked after people very well. One relative said they felt confident in the staff and, "Able to take a day off and know the staff are providing the care and support (name) needs" and, "The staff are very good." Another relative told us, "The staff try their best they are all very caring." However, despite these positive comments we found there were areas for improvement.

Staff said they provided care and support in a kind way and made sure they protected people's dignity. However, we observed there were occasions when staff did not do this. For example, one person was moving around in their armchair, pulling at the electrical lead from their pressure relieving cushion and trying to reach electrical wall sockets. A member of staff noticed this and pulled the person's chair from behind, without explaining what they were doing or talking to them. The person's chair was then repositioned away from the wall and plugged into a socket in the floor. The member of staff was trying to ensure the person's safety, but had not considered the effect on the person of not knowing what was happening and not seeing who was moving them. In addition, staff had failed to consider what they could offer the person to help reduce their anxiety, which was apparent from the body language they were displaying. Staff moved two other people in their chairs in the same way, staff did not talk to people before or while they moved them.

Staff described how they offered people choices about their daily lives and knew what people's preferences were, for example, what time they liked to get up, or whether they would like tea or coffee. One member of staff said, "We ask if they want to get up, what they want to wear and what food they want. They are all treated equally." Another member of staff said, "One resident has TV on all the time at night sleeping through it, so when waking up can watch it. Their choice."

However, staff did not consistently ask people what their preference was. For example, when people came into the lounge, they were not always asked where they would like to sit. Staff knew that two people preferred to sit next or near to each other. On occasions, both people were not supported by staff to sit within sight of each other. This caused one person to become distressed, and they frequently repeated, "Oh dear, oh dear", while rocking themselves backwards and forwards in their chair. During our observation, staff did not take action to relieve the person's distress. When we pointed this out to staff, they helped the people sit next to each other, which immediately helped calm the person's anxiety. We heard a conversation between a person and staff. The person was offered a cup of tea by the member of staff. They said, "I don't like, I don't like tea." The member of staff asked the person "Do you want coffee?". The person did not reply, so the member of staff left the tea, and carried on with the next task.

On day one of the inspection, the atmosphere in the lounge was not relaxed and there was a lot of background noise, with music and the TV on at the same time for most of the day. The sunny weather meant the room was hot and airless with the sun shining down through the pyramid skylights although staff re-positioned people and ensured they were not sitting directly under the sun. People were not supported to sit out in the garden, although it was warm and the internal courtyard was easy to access from the lounge. The registered manager said they had arranged to have a film attached to the skylights, which would reduce the glare from the sun, and this was completed during the inspection.

Staff did not always promote respectful and compassionate behaviour within the staff team. For example, on day one of the inspection, we saw two separate occasions when a person asked the nearest member of staff for something and the member of staff asked another colleague to help the person, instead of supporting the person themselves, with no explanation. One person asked a registered nurse for a sandwich which was on a table in the room. The nurse did not get the sandwich for the person, but asked another member of staff to do this for them. Another person needed some interaction with staff and appeared slightly distressed. A registered nurse noticed this and looked around to see what the activity staff was doing, they were already supporting someone else and were not free. The registered nurse did not sit with this person to talk to them or offer any activity to reduce their distress.

The provider had failed to ensure that people were treated with respect at all times and that support was offered in a kind and compassionate way. Staff were not consistently treating people in a kind and compassionate way and we observed staff were carrying out tasks rather than thinking about people's individual needs. People were not always treated with dignity and respect and staff did not always support people's autonomy and independence. These were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On day two of the inspection, a different staff team was on duty. They said the daily allocation including which house/lounge staff would work, the time for breaks, who to assist with teas, do supper menu and mid-afternoon teas, should be agreed during handover first thing. So that everyone knows what they are doing and can plan the support properly and, the allocation form is kept in the lounge for staff to refer to if necessary. We observed staff spent more time with people. For example, one member of staff used the 'butterfly technique' to talk to and engage with people through regular brief contacts. They explained this technique was person centred and involved staff shifting their focus from only doing 'tasks' to communicating with people in a meaningful way for short periods. The member of staff told us, "I love the residents. Like to talk to them all and make them smile." People were clearly pleased to talk to them and their facial expressions were happy and smiling.

We spoke with nurses and the registered manager about the difference between the two staff teams. One nurse said they were disappointed staff had provided care in the way they did, and that incidents we observed should not have happened because they were not 'professional'. The nurse was committed to discussing this with the team, and to provide the support they needed to improve their approach to people. We discussed staff with the registered manager and they acknowledged that staff behaviours were not consistent and, "It depends which staff are on duty."

Staff said they enjoyed working in the home. Their comments included, "I love working here." "Lovely home and residents are supported to live well" and, "I love my work." We observed a member of staff providing very good care for a person when they were upset and said they had difficulty breathing. They sat beside the person and advised them to sit up straight and lift their chin up. This settled quickly and they were able to breathe more easily. The member of staff also sat with the person later when they were upset as they want to see their relatives. They told us, "I like to talk to residents and I think the interaction and communication here is very good."

Relatives and friends were able to visit at any time and staff said they encouraged people to maintain these relationships. People and their relatives gave us positive feedback about the staff. One relative said staff were, "Like a second family" and another said, "They are very caring."

Requires Improvement

Is the service responsive?

Our findings

At our inspection on the 30 December 2014 and 12 January 2015 we found the provider was not meeting the legal requirements in relation to the provision of appropriate activities based on people's preferences. At the inspection in September 2016 we found these improvements had not been made which was a continued breach of regulations. At this inspection we found the provider remained in breach of regulations, and we identified other areas where improvements were also required.

The provider had aimed to make improvements to the activities offered to people, by appointing a member of staff specifically employed to provide activities in the afternoon. However, they member of staff had not been given training on how to support people with dementia to take part in meaningful activities, or understand what activities were appropriate for people living with dementia. The activity person asked people if they would like to join in some games and offered a balloon to some. We saw from one person's facial expressions that they were hitting the balloon away because they did not want it near them, and another person was knocking the balloon against their table rather than joining in. Other games were also offered but people declined the game suggested, or did not respond in any way to staff. Some people were given magazines or books to look at, but people were generally sitting quietly with very little communication with staff, or each other, during both days of the inspection.

Feedback about the activities on offer was poor. One person said, "They are good here but I am bored, bored, bored," and, "They give me magazines but they are not enough, and the games are silly, I want to go out and see different places, go to the seafront, I like the seafront." Another person told us, "There is nothing to do here, nothing." A visitor told us their friend was a, "Very social and active person and loved crosswords….Then moved here. Now all they do is sit here doing nothing." A registered nurse told us that activities needed to improve saying, "We need a proper structured programme" and, "We need to get some people out."

Two relatives described how music had been an important part of their family member's life and they liked to sing in a choir or listen to classical music. The relatives said these interests were not supported by staff and one of them said, "When I come in I bring music for him to listen to, to keep him active as much as possible as they (staff) don't have time to." Another relative told us about their family member's love for classical music. When they visited they went to the person's room to listen to music. We asked if staff were aware of the person's love for this style of music and the relative replied, "Oh no, I don't think they'd be interested in Beethoven somehow."

Staff started an exercise to music group after lunch. Several people were engaged with the exercises and joined in, but some people had not been supported to be involved as much as they would like. People were spread out over a large area and one person was leaning around a pillar so they could see what was going on and hear the music. Other people were too far away from the activity staff to take part. Two visitors told us the music played for the class was the same every day and one commented they knew the music, "Like the back of my hand," as they played the same CD every day.

The provider had failed to ensure staff had appropriate guidance to follow, based on current guidelines, for the provision of support for people that met their needs and reflected their preferences. This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager said they had been reviewing people's care plans and a number of changes had been made. However, we found people's care plans were not personalised and did not focus on people as an individual. There was a considerable amount of information, under the same headings for each person and some was repetitive and unclear. For example, one person had four different falls risk assessments in their care plan, when there was no apparent risk of risk of falling. This was the person was mostly cared for in bed and were unable to walk or get out of bed on their own. They needed the support of staff, and the use of equipment to help them move around the home.

Some of the information recorded about people was either incorrect or staff did not know how to provide appropriate support. For example, one person's care plan stated, 'I am quiet and softly spoken'. One member of staff said this person was unable to communicate their needs by talking, but other staff said if they asked the person a question like, "Do you want a drink?" and waited for a response they would say yes or no and you, "Just need to give them some time to reply." The person was described as 'approachable and friendly', but it was not clear how staff had come to this conclusion or what this meant to the person's daily life. This placed the person a risk of inconsistent support.

Staff spoke about peoples' individual needs and preferences, but they did not always follow the person's care plan. For example, one person's care plan detailed the person needed continence aids. We observed this person in the lounge most of the day. The person was not provided support in accordance with their assessed needs, and the guidance for staff was unclear about how often the person should be supported to manage their continence . The person was unable to ask for assistance, so it was important their care plan provided clear, up to date guidance which reflected their needs. A staff member told us they do not read people's care plans as, "They don't have the time" and "they are for the nurses really."

We saw the term, 'treat him/her with kindness, respect and compassion' repeated frequently through people's care plans. This was a generic statement in each person's care plan, but there was no information about how staff should do this. Some people could become anxious or upset, and although this was recorded, there was no information about what staff should do to help people reduce their anxiety or people's individual triggers. Care plans stated, 'what makes me feel better if upset or anxious'. A response was included to guide staff on how to support people with anxiety, but detailed information was not given about how staff should do this. Care plans did not state how staff would know if a person was upset or anxious, either by the person's vocalisations or body language. We observed one person to be at anxious at times during the day. Staff did not spend time sitting and talking with the person, and they were not reassured about their concerns.

The provider did not make sure people experienced person centred care that met their needs and reflected their personal preferences. This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said they were aware of their roles and responsibilities. They said they worked very well together as a team, with the same aim, to provide good, personalised care for people living in the home. They thought they provided this, despite the records, they knew people very well and were happy to talk about how they supported them.

Feedback about making a complaint was mixed. A relative said they had a lot of complaints and had struggled to get a response from the provider and owner of the home. They said, "It's a complete waste of time even talking to him." The relative then went on to say, "I am glad (registered manager) is here now as he really does his best to sort out problems." Another relative told us they were, "Much happier now, no complaints or worries, feels the staff keep me up to date with what's going on, with care for (name) and any changes in the home. There had been two written complaints since the last inspection and records showed these had been resolved following meetings and discussions with relatives.

Inadequate

Is the service well-led?

Our findings

At our inspection in September 2016 we found the provider had failed to ensure that an effective quality assurance and monitoring system was in place to identify areas for improvement and to develop the service to meet people's needs. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although there had been some small improvements at this inspection, we found the provider remained in breach of this regulation.
Previously, the provider had also failed to ensure that a consistent registered manager was in post. Having a registered manager is a condition of their registration. At the last inspection there was a new manager who had been in post for nine weeks. That person has remained in post and is now the registered manager.

We asked the registered manager what improvements they had made since the last inspection. They told us they had been addressing people's concerns and reviewing all aspects of the service. Examples included arranging more training for staff, reviewing people's care plans and liaising with relatives and the local authority. The registered manager acknowledged the home had been through some challenging times and was still, "A work in progress." The registered manager said the provider was supporting them with the improvements and if there was something they needed, such as additional hoists and slings, they would get it.

Although there were quality monitoring processes and audits in place, the registered manager was not using these tools effectively, to continue to identify areas of practice that required improvement. The audits we reviewed included people's care plans, cleanliness standards and activities, among others. The documents were based on a 'yes/no' format which identified when tasks had been done, but did not include any details to help inform a quality audit, and had not identified any of the concerns we found during this inspection.

We discussed the provider's quality monitoring with the local authority, East Sussex County Council (ESCC). They confirmed that in 2016, they had given extensive support to the provider, to help them improve their quality monitoring and consequently the quality of care people experienced. ESCC also felt the provider and registered manager approached quality monitoring as a 'tick box exercise' and did not understand that effective audits and quality monitoring can improve people's quality of life.
A recurring theme through previous inspections has been a lack of meaningful activity for people, poor social inclusion and limited support to maintain contact with the local community. When we reviewed the current audits, one form asked 'are activities planned and arranged in accordance with the recorded preference of the individuals living in the home' to which the registered manager had answered, 'Yes'. However, as relatives told us and as we observed, activities have not been developed in line with people's preferences or needs. Although people's preferences were listed in their care plans, their activity of preference was not being provided. The activity person had attended training in providing activities for people living with dementia, but the provider had not ensured this training had been effective. The activity person did not have all of the skills they needed to provide person centred activities. The registered manager had not identified any of these concerns when they completed their quality checks. They had not taken action to make sure the quality of activities had improved and people's social needs were met.

Other examples of ineffective quality monitoring included the 'meal time' audit. This is an area of practice where concerns had been identified at this inspection and these had not been addressed. No concerns had been identified by the registered manager. One section stated, 'Is cream added to the puddings of residents who are identified on a high calorie diet?' with the answer 'Yes' and 'Action needed – instruct staff to collect cream from the kitchen and add to meals'. We noted everyone living in the home was being served fortified food, even if they had been identified as needing a low calorie diet.

At the last inspection we found the provider had a plan to deal with an emergency and a contingency plan was in place to move people to a nearby home if people there were an emergency. Personal emergency evacuation plans (PEEPs) had been completed for everyone but we found some of the information recorded was different from care plans and risk assessments. For example, two risk assessments stated people used walking aids, a stick or a Zimmer, and the assistance of one member of staff to move around the home. In the PEEP it stated the people were immobile and a hoist and wheelchair would be needed to assist them to move to a safe area. At this inspection we found that although staff were now familiar with how to support each person to evacuate the building, records had not been updated with information about people's current mobility needs. At the last inspection the registered manager said they would review the records to ensure they reflected people's needs, but this had not been done. Therefore there remained a risk of staff using inappropriate aids to support people to leave the building which may put them at risk of harm.

The provider had received on going support from ESCC to promote improvements to ensure they met the regulations. In addition, the provider had employed an external consultant to identify areas where improvements were needed and to provide feedback when these had been made. We found from the reports provided by ESCC that there were concerns with record keeping, including conflicting information regarding moving and handling and people's social and dining preferences. These were areas of poor practice which continued, and were identified during this inspection..

The report from the external consultant stated in April 2017 that, "The management have a clearer idea of the challenges they face and have made progress towards each of the areas, laying a foundation from which to build on" and listed areas where further improvements were needed to meet the regulations. Their detailed plan for CQC compliance included, 'Clinical skills competencies for both new RN (Registered nurses) and support workers need to be compiled. These would provide evidence that new staff have received the required training and had been assessed as being competent in these skills in order to provide safe care', and, 'New staff must be provided with an experienced mentor in order to provide support to new staff' by end of April 2017. Although the provider told us they had introduced clinical skills competencies and a 'buddy system' for staff, we did not see evidence that these systems had been effective. The provider and registered manager had not made sure staff had the knowledge and understanding of people's needs to ensure that these were met. The provider and registered manager continued to fail to act on feedback, and had not provided effective leadership and direction at the service.

Despite the input from ESCC and the external consultant the quality assurance and monitoring system was not consistently effective. Although some improvements had been made since the last inspection, such as staff recruitment, there were on going breaches of regulations. The registered manager and provider's monitoring of the service had not identified these breaches. There were several occasions when we observed people did not experience consistently good care, and the registered manager had not ensured the effective supervision of staff to make sure people experienced safe care and support.
The provider and registered manager had failed to make sure they had a system in place to effectively monitor the quality of the service they provided. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Feedback from staff, people and relatives about the actions taken by the registered manager was positive. Comments from staff included, "since the new manager, things have improved massively. There is direction and stability, which is good." Staff described how "things had settled down since the registered manager had started work, and that the registered manager was "very positive to staff and offers praise and thanks". A relative said, "I am glad he (the registered manager) is here now as he really does his best to sort out problems" and he, "does try his best".